Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: MID-TOWN SURGERY CENTER, LLP C/o Gilbert & Maxwell, PLLC P. O. Box 1984 Houston, Texas 77251	MDR Tracking No.: M4-04-3008-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: NATIONAL AMERICAN INSURANCE CO. C/o ECAS Box 02	Date of Injury: Employer's Name: Greenfield Industries, Inc. Insurance Carrier's No.: XI013401

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"It is Mid-Town Surgery Center's position that this facility correctly and appropriately coded and billed for the surgical (Needle Localization under fluoroscopy & Lumbar epidurogram without dural puncture) procedure performed on ___ on 11/07/2002. Each and every item and service necessary for this medical care, including pre-operative and post-operative care, were documented thoroughly."

Principle Documentation:

1. Table of Disputed Services
2. UB-92
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary as stated on letter from Carrier dated 12/16/03 states, "We agree with CorVel's review and request the Medical Review Division to find the amount reimbursed to be fair and reasonable and the requestor is due no more monies for these dates of service."

Principle Documentation:

1. Position Summary
2. Summary of Adjusted Charges

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
11/07/02	Ambulatory Surgical Center Care	1	$0.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

1. This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

After reviewing the services, the charges, and both parties' positions, it is determined that no other payment is due.

During the rule development process for facility guidelines, the Commission had contracted with Ingenix, a professional firm

specializing in actuarial and health care information services, in order to secure data and information on reimbursement ranges for these types of services. The results of this analysis resulted in a recommended range for reimbursement for workers' compensation services provided in these facilities. In addition, we received information from both ASCs and insurance carriers in the recent rule revision process. While not controlling, we considered this information in order to find data related to commercial market payments for these services. This information provides a very good benchmark for determining the "fair and reasonable" reimbursement amount for the services in dispute.

To determine the amount due for this particular dispute, staff compared the procedures in this case to the amounts that would be within the reimbursement range recommended by the Ingenix study (from 173.9 % to 226.5% of Medicare for year 2002). Staff considered the other information submitted by the parties and the issues related to the specific procedures performed in this dispute. Based on this review and considering the similarity of the various procedures involved in this surgery, staff selected a reimbursement amount in the Ingenix range. CPT Code 99082 on Table of Disputed Services is for unusual travel. The provisions in Rule 134.6, do not extend to healthcare providers submitting casual charges for courtesy transportation. Travel reimbursement is a conditional benefit for injured workers only. The health care provider is seeking reimbursement in the same manner that professional services are reimbursed. This method of reimbursement is inappropriate for facility billing. The decision for no additional reimbursement was then presented to a staff team with health care provider billing and insurance adjusting experience. This team considered the decision and discussed the facts of the individual case.

Based on the facts of this situation, the parties' positions, the Ingenix range for applicable procedures, and the consensus of other experienced staff members in Medical Review, we find that no additional reimbursement is due for these services.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.1
28 Texas Administrative Code Sec. 134.6
28 Texas Administrative Code Sec. 133.307

PART VII: DIVISION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Ordered by:

Authorized Signature	Typed Name	October 17, 2005 Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.